TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
D.G. Eaves, D.C.

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-17-2095-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
March 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I performed a DDE on the above-mentioned patient on 10.25.2016 and submitted the report along with the appropriate billing to the adjuster noted on the DWC form 32 for this evaluation. The initial submission by fax was made on 11.03.2016. When that submission was not considered, reconsideration was submitted on 01.16.2017. The attached EOR received in response to the reconsideration request continues to reflect no reimbursement paid for this TDI DWC ordered examination."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2016	Designated Doctor Examination	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work and evaluation of medical care examinations.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00214 – (W3) Request for reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is D.G. Eaves, D.C. entitled to reimbursement for the disputed service?

Findings

Dr. Eaves is seeking reimbursement of $500.00 for a designated doctor examination to determine the extent of the compensable injury. Review of the submitted documentation finds that ACE American Insurance Company failed to articulate a reason for the denial of the examination. Therefore, the division concludes that Dr. Eaves is entitled to reimbursement of $500.00 for this examination, in accordance with 28 Texas Administrative Code §134.235.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	June 9, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.